Taxsaver Plan True Up Claim Form Instruction Sheet

Please complete the steps below to submit the Standard Claim Form. Incomplete submissions may result in delays in processing your request. Taxsaver Plan will contact you if more information is required to process your claim.

Submit your claims to:

Taxsaver Plan
P.O. Box 609002
Dallas, TX 75360
214-528-8122 FAX
claims@taxsaverplan.com EMAIL
www.taxsaverplan.com SECURE WEBSITE

- Print the full Employer Name, Participant Name, and Social Security Number (at least the last 4 digits) in the spaces provided.
- Fill in the total amount you are claiming for each plan that applies to your request. If your employer offers more than one type of plan, you may submit expenses for any of them using the True Up Claim Form. For health care expenses, please note which amounts apply to your employer-sponsored insurance plan, and which amounts do not – then mark the total in the space provided.
- Sign and date the Participant Certification section of the form.
- Attach documentation from the service provider for each expense you are claiming. See below for specific information on what documentation is necessary for each Plan type.

Please Note:

-You may use this form to request reimbursement for expenses if your Employer offers a Dependent Care Reimbursement Plan. Just complete the 'Dependent Day Care Expenses for Reimbursement' section as well as the 'Participant Certification for Reimbursement' section. Not all employers offer this type of plan through Taxsaver Plan.

-If you are enrolled in the True Up Plan, you are not required to submit documentation to back up any Flex Debit Card charges unless you receive a written request.

-For Flex Debit Card transactions only: You may simplify your submission process by using the Debit Card Substantiation Worksheet. You'll find it in the 'Forms' section of our website.

Dependent Care Assistance Program (DCAP):

You must submit itemized receipts that include the date of care, amounts paid for care and the name of the provider OR have your provider sign and date the form certifying that services have been rendered.

True Up Health Flexible Spending Arrangement (TU FSA):

Acceptable documentation for expenses include:

1. Health Plan receipts (Explanation of Benefits) sent from your insurance plan provider that substantiate deductibles, copays, coinsurance or other expenses applicable toward or covered by the employer-sponsored plan that covers you, your spouse and/or any eligible dependents.

2. Itemized receipts (as indicated above in the Health Flexible Spending Arrangement section) are acceptable for expenses for yourself or any eligible dependents that are not applicable to or covered by your employer-sponsored insurance plan. You must indicate which portion of your total claim is applicable toward your insurance plan and which portion is not.

True Up Plan Flexible Spending Account Claim Form

Submit Claims To:
TaxSaver Plan
P.O. Box 609002
Dallas, Texas 75360
214-528-8122 FAX
claims@taxsaverplan.com

_____ _____
Name of Employer (please print) **Social Security Number (or last 4 digits)**

_____ _____
Employee Last Name (please print) **First Name**

Dependent Day Care Expenses for Reimbursement

Required Documentation: You must submit itemized receipts that substantiate the date of care, amounts paid for the care and the name of the provider OR have your provider sign the Dependent Day Care Reimbursement portion of the claim form certifying that services have been rendered and are for the care of my eligible dependent(s).

$_____ Service Dates of Day Care from __ / __ / ___ to __ / __ / ___.

_____ _____
Date **Day Care Provider Signature** *Please note the employee must still complete the Participant Certification portion of this form.*

Health Care Expenses for Reimbursement

For your convenience, this FSA plan allows your participating insurance carriers to automatically send TaxSaver Plan documentation of certain expenses that you, your covered spouse, or your covered dependents have incurred during the FSA plan year for which you are responsible to pay. This information will be sent directly to TaxSaver Plan, and we will match it against any debit card transactions to substantiate the transaction. By using this form to submit expenses for reimbursement, you certify that the expenses submitted have not already been paid for with the Flex Debit Card.

- Out of pocket expenses for reimbursement applicable toward your insurance plan $_____
- Other out of pocket expenses for reimbursement not applicable toward your insurance plan (such as OTC items or expenses for dependents not covered by your employer sponsored insurance plan) $_____

TOTAL Claim for reimbursement $_____ **TOTAL Flex Debit Card expenses $_____**

Required Documentation: Acceptable documentation for expenses include:

- Health Plan receipts (Explanation of Benefits) sent from your insurance plan provider that substantiate deductibles, copays, coinsurance or other expenses applicable toward or covered by the employer-sponsored plan that covers you, your spouse and/or any eligible dependents.
- Itemized receipts are acceptable for expenses for yourself or any eligible dependents that are not applicable to or covered by your employer-sponsored insurance plan. The itemized receipts must be from providers, and must substantiate the date of service, type of service, cost of service and the name and phone number of the provider. Itemized receipts for eligible over-the-counter expenses must have the name of the drug or item and the date of the purchase printed on the receipt from an independent third party. **Please note:** balance forward statements, canceled checks and credit card receipts are not acceptable.

Participant Certification

This section must be signed and dated for all reimbursement requests.

I testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my spending account, they may not be claimed on any federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party such as my major medical plan or any other health plan, an individual policy or my spouse's or dependents health plan. If this expense was paid for with my Flex Debit Card, I understand that the card is not to be used for personal items other than eligible expenses under the plan. Should I use the card for ineligible expenses, I am required to reimburse the plan for the ineligible expenses paid for with the card. I attest that any over-the-counter expenses have been incurred for the primary purpose of the alleviation or prevention of a physical or mental defect or illness and is not for cosmetic purposes and will be used by myself, spouse and/or dependents. All expenses submitted for request of reimbursement or claim substantiation are for myself and/or qualified spouse and/or qualified dependent(s)under federal guidelines.

_____ _____
Date **Participant Signature**